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IRO CASE

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Right Shoulder Rotator Cuff Repair, Subacromial Decompression with Acromioplasty, Open Biceps Transplantation.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Board Certified Orthopedic Surgeon with over 13 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld

(Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on XX/XX/XX while working. A male X appeared that he was going to "attack" a female so the claimant confronted the man, who proceeded to swing punches towards him and then threw the claimant over a sofa, landing onto his right shoulder. He presented to the ER that day and was diagnosed with a shoulder contusion, prescribed topical diclofenac gel and po methocarbamol (neither of which he filled) and provided with an arm sling.

09/10/15: Encounter Notes: Pt presented with right shoulder pain to the anterior and superior aspects of the shoulder. The pain radiates down towards right forearm when trying to raise his right arm. He reported wearing the sling since receiving it. On physical examination he had very limited ROM with abduction to about 80 degrees and flexion to about 30 degrees. There was tenderness to palpation to anterior and superior aspects of the right shoulder, no right clavicle tenderness to palpation. There was significant weakness with right shoulder motor testing, particularly with external rotation. 2+ right radial pulse. Right shoulder e-rays were unremarkable. He was placed on Motrin 800 mg po q 6 hrs prn. He was advised to discontinue the sling and was provided with a shoulder ROM handout. A right shoulder MRI was ordered.

09/16/15: MRI Right Shoulder without contrast: Impression: 1. The patient has sustained a complete full-thickness retracted tear involving the supraspinatus tendon. The tendon is retracted approximately 2.9 cm, there is no convincing evidence of muscle belly atrophy. 2. Biceps long head tendon is medially dislocated. This indicates concomitant partial thickness subscapularis tear. 3. Acromioclavicular osteoarthritis with subclavicular osteophytic spurring.

09/17/15: Encounter Notes: Pt presented doing a little better, but his shoulder still hurt a lot when picking something up. He also reported some "popping" to his right shoulder. He was instructed to continue Motrin and

ROM exercises and was referred to orthopedics.

09/18/15: Office Visit: Pt was seen for sharp, severe right shoulder pain that is constant. He has significant weakness and feels pain at night. Medication makes him feel slightly better. On examination he had 5/5 strength in elbow flexion/extension, wrist flexion/extension and hand intrinsics. ROM and stability of the left shoulder was full and intact. There was gross pain to palpation over the anterior right shoulder. Gross weakness to supraspinatus strength testing. Full passive ROM but pain at the extremes. He did not have forward flexion approximately 120 degrees and significant weakness. Abduction to 95 degrees and then pain and weakness. No instability of the right shoulder. X-rays shoulder moderate a.c. joint DJD. Type II acromion. Right shoulder arthroscopy and rotator cuff repair along with biceps transplantation and subacromial decompression with partial acromioplasty was recommended.

10/06/15: UR: Decision: An MRI report indicating rotator cuff pathology has not been provided for direct review, as the official radiology report was not provided in the records reviewed. Additionally, the Guidelines would not support acromioplasty without objective documentation of three to six months of conservative treatment failure, including formal physical therapy, oral medication, activity modification, trial corticosteroid injection. Clarification was needed from the requesting physician in order to approve this request, especially since the radiologist report was not included in the records. The request for right shoulder rotator cuff repair, subacromial decompression, acromioplasty, and open biceps transplantation is not authorized.

10/07/15: UR: Decision: While the radiology report indicated a full thickness retracted supraspinatus tear with dislocation medially of the biceps long head and with a type II acromion present, the medical records did not document, on physical examination, provocative impingement findings for which an acromioplasty with subacromial decompression would be additionally indicated. Although, at the time of surgery, impingement is found on the cuff repair an acromioplasty should be performed, but being unable to modify this request in such a manner, the entire request is not medically necessary.

11/09/15: Follow Up Note: Pt presented with very weak forward flexion with poor active motion. He had a positive drop arm test. Grossly positive Neer and Hawkins test. Positive O'Brien's test. Tenderness globally throughout the shoulder. Abduction was to only 100 degrees. External rotation to 45 degrees. Internal rotation to the side. No instability but pain.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse determinations are upheld. The request for right shoulder rotator cuff repair, subacromial decompression with acromioplasty, open biceps transplantation is denied.

This patient is currently dealing with pain and weakness in the shoulder following injury. His shoulder MRI demonstrated a rotator cuff tear with 2.9 cm of retraction. There is no evidence of muscle atrophy, consistent with an acute injury. His biceps tendon is medially subluxed.

The Official Disability Guidelines (ODG) supports rotator cuff repair in the patient with a documented rotator cuff tear who has failed three to six months of conservative care. Prior to surgical consideration, the patient should have subjective and objective clinical findings, consistent with a rotator cuff tear identified on an imaging study such as MRI.

Based on these criteria, this patient is not a surgical candidate because he has not completed three to six months of conservative treatment. There is no documentation of failure of physical therapy, medication or cortisone injection. These criteria have not been met prior to the recommendation for surgical repair. Therefore, the request for Right Shoulder Rotator Cuff Repair, Subacromial Decompression with Acromioplasty, Open Biceps Transplantation is not found to be medically necessary at this time.

PER ODG:

ODG Indications for Surgery™ -- Rotator cuff repair:

Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out:

- 1. Subjective Clinical Findings:** Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS
- 2. Objective Clinical Findings:** Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS
- 3. Imaging Clinical Findings:** Conventional x-rays, AP, and true lateral or axillary views. AND MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.)

- 1. Conservative Care:** Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS
- 2. Subjective Clinical Findings:** Pain with active arc motion 90 to 130 degrees. AND Pain at night (Tenderness over the greater tuberosity is common in acute cases.) PLUS
- 3. Objective Clinical Findings:** Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS
- 4. Imaging Clinical Findings:** Conventional x-rays, AP, and true lateral or axillary view. AND MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

([Washington, 2002](#))

For average hospital LOS if criteria are met, see [Hospital length of stay](#) (LOS).

ODG Indications for Surgery™ -- Acromioplasty:

Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.)

- 1. Conservative Care:** Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS
- 2. Subjective Clinical Findings:** Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS
- 3. Objective Clinical Findings:** Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS
- 4. Imaging Clinical Findings:** Conventional x-rays, AP, and true lateral or axillary view. AND MRI, ultrasound, or arthrogram shows positive evidence of impingement.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**